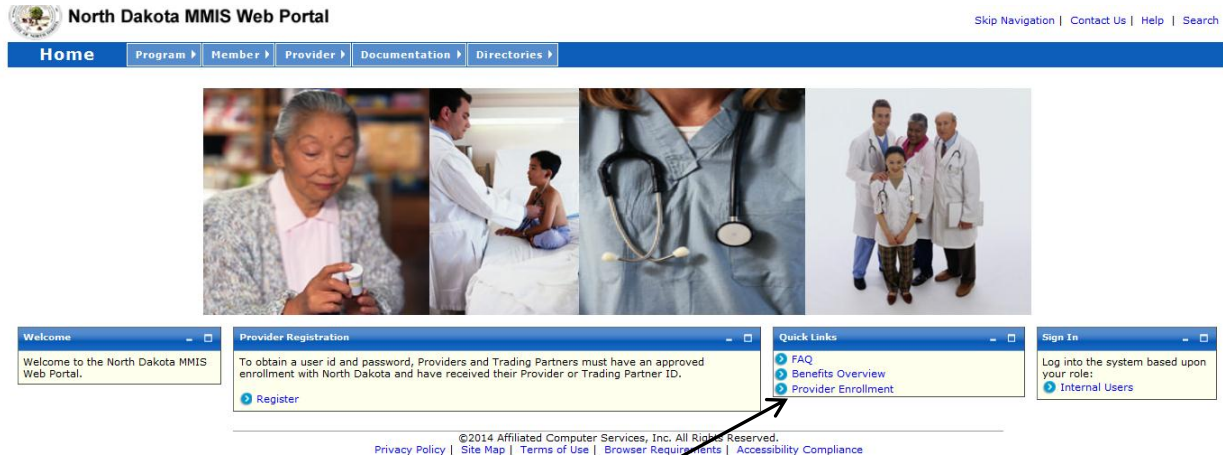


# QSP AGENCY PROVIDER APPLICATION INSTRUCTIONS

STEP 1: Go to the website link listed below.

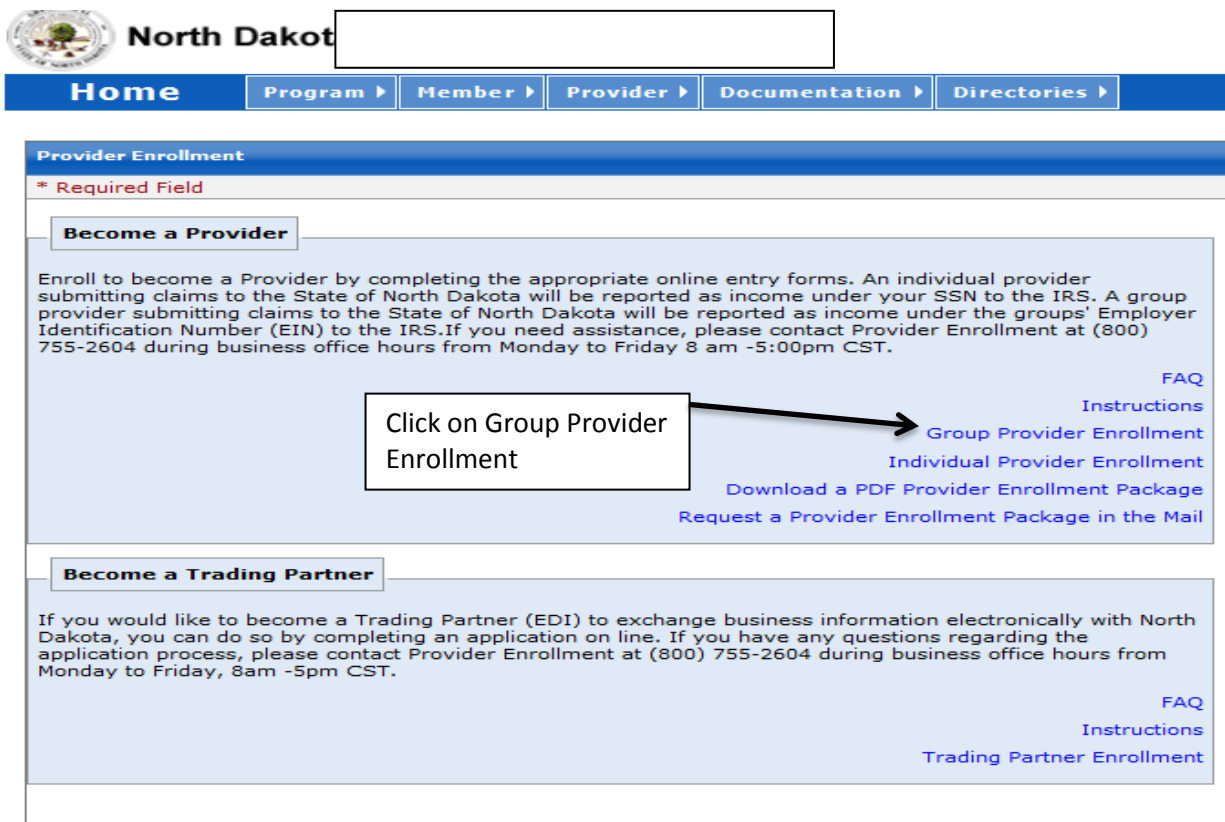
<https://mmis.nd.gov/portals/wps/portal/EnterpriseHome>

You should see this screen:



STEP 2: Click on **Provider Enrollment**

STEP 3: Your screen should appear like this: Click on **Group Provider Enrollment**



STEP 4: Click on **Continue**

North Dakota MMIS Web Portal

Mar 10, 2014

Skip Navigation | Contact Us | Help | Search

Home Program Member Provider Documentation Directories

Instructions

Print Help

\* Required Field

Application Links

- Instructions
- Agreement

Group Provider Enrollment Instructions

- If you are applying for both an individual provider number and a group provider number, you must complete a separate application for each number.
- For all date fields, use the date format (mm/dd/yyyy) unless otherwise indicated.
- Complete all areas of the application, unless otherwise indicated.
- After completing each page of your application, click the "Continue" button to proceed through the application process.
- If additional information is necessary to complete the application please attach the necessary documents to the identifying cover page that will be provided at the end of the application.

This application is for a group practice or facility. Please enroll using your Employer Identification Number (EIN). If you are enrolling with a Social Security Number (SSN), then you must complete the Individual Enrollment Application.

Continue>> Cancel

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Click on Continue

STEP 5: Click **Accept**

North Dakota MMIS Web Portal

Mar 10, 2014

Skip Navigation | Contact Us | Help | Search

Home Program Member Provider Documentation Directories

Provider Enrollment

Print Help

\* Required Field

Application Links

- Instructions
- Agreement

Please ACCEPT or DECLINE this participation agreement.

Provider Acknowledgement

- I attest that the following information is true and correct to the best of my knowledge. Providing false information may be the basis for the North Dakota Department of Human Services refusing or revoking any provider agreements.

Accept Decline

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Click Accept

There is a **Help** area in the **left hand column** of the page. This provides an explanation of the information required and assistance in navigating the application.

Any field marked with a **red asterisk** is required.

STEP 6: Enter the information as prompted on the screen

The screenshot shows a multi-section form for enrollment. The sections are: Group Information, Tax Reporting Information, Current/Previous ND Provider #, and Non Profit Organization Tax Exempt Status. Annotations include a callout box for EIN entry (Use 12/31/9999 as the EIN end date), a large instruction box for the ND Provider # section, and arrows pointing to the 'Add Previous ND Provider #' button and the 'Save' button at the bottom.

**Group Information**

\*Group Organization Name  \*Years Doing Business Under this name

? Have you ever used a different Doing Business As (DBA) Name? ☐ Yes ☐ No

**Tax Reporting Information**

? \*Legal Name  \*EIN

\*Begin Date  \*End Date

Use 12/31/9999 as the EIN end date.

**Current/Previous ND Provider #**

Please enter your current and/or previous ND provider numbers.

**Previous ND Provider #**

ND Provider #

Add Previous ND Provider #

**Non Profit Organization Tax Exempt Status**

Is this business listed under tax exempt status? ☐ Yes ☐ No

Click on Add Previous ID Provider #. A drop down box will appear. Enter your current provider number starting with 4 zeroes. Example: 000033598. **IF YOUR INITIAL ENROLLMENT DATE IS AFTER 03/27/13, DO NOT ADD A PREVIOUS PROVIDER NUMBER #. Refer to the cover letter to find your initial enrollment date.** Click on the blue **Save**.

**Current/Previous ND Provider #**

Please enter your current and/or previous ND provider numbers.

**Previous ND Provider #**

ND Provider #

Add Previous ND Provider #

Save | Reset | Cancel

\*ND Provider #

When entire page is completed, click the blue **Save** box on bottom of page.

You should see the following message at the top of the page:

The Provider Enrollment details have been saved successfully. Please note your Application Tracking Number ##### for future access to the Enrollment Application.

Write the tracking number down: TRACKING NUMBER: \_ \_ \_ \_ \_.

STEP 7: Click on **Licensure/Certification** in the left hand column **or** the **Continue** button at the bottom of the page.

**Application Links**

- Application Tracking Number - 130840
- Instructions
- ✓ Identifying Information
  - ▶ **Licensure / Certification**
  - Provider Identifier Numbers
  - Service Location / Billing Information
  - Group Affiliation
  - Electronic Transaction Submission
  - Ownership
  - Authorized Reps
  - Exclusions / Sanctions
  - Qualified Service Providers

STEP 8: Chose **Qualified Service Provider** as the **Provider Type**.

**Provider Type**  
\*Provider Type  
Qualified Service Provider

STEP 9: If your agency has licensures/certifications click on the **Add Licensure / Certification** button You will then see a drop down box. Fill in the boxes, then click on the blue highlighted **Save**. If you have more than one license click on the **Add Licensure/Certification** button again. Repeat as needed to add more.

**Licensure and Certification - Section 2**

**Licensure and Certification List** Add Licensure / Certification

License Number^v	Certification Number^v	State^v	Lic/Cert Agency^v	Effective Date^v	Expiration Date^v
------------------	------------------------	---------	-------------------	------------------	-------------------

**Add Licensure and Certification** Save | Reset | Cancel

\*Add all licenses and certificates. For each instance, indicate if you are entering a license or a certification.  
Are you adding License or Certification information?  
☒ License ☐ Certification

\*Provider Type  
Qualified Service Provider

\*License Number

\*Licensing Agency

\*Effective Date

\*Expiration Date

State  
North Dakota

STEP 10: Add your enrolled services one at a time following the directions below. A service is named a 'specialty' in this MMIS application.

**Board Certified Specialty List**

**Note:** Enter information for all the specialties for which you are board certified or eligible, certification or eligibility.

**Specialty List**

Specialty	Provider Type	Certification #	State	Board name	Begin Date	End Date
<div> <div> <div> <div>*Specialty</div> <div></div> </div> <div> <div>*Provider Type</div> <div>Qualified Service Provider</div> </div> <div> <div>*Begin Date</div> <div></div> </div> <div> <div>*End Date</div> <div></div> </div> </div> <div> <div> <div>*State</div> <div>North Dakota</div> </div> <div> <div>*Certification #</div> <div></div> </div> <div> <div>*Board name</div> <div></div> </div> </div> </div>						

[Add Specialty](#)
[Save](#) | [Reset](#) | [Cancel](#)

**Annotations:**

- Click on the **Add Specialty** button. Enter your enrolled services one at a time. Click **Save** after each service entered.
- Begin Date: Always use 10/01/2013
- End Date: Always use 12/31/9999
- Certification #: Always use 12345
- Board Name: Choose Unknown

STEP 11: Skip the Taxonomy section at bottom of this page.

**Taxonomy**

**Taxonomy Code**

[Add Taxonomy](#)

Taxonomy	Begin Date	End Date
<div> <a href="#">Continue&gt;&gt;</a> <a href="#">Save</a> <a href="#">Reset</a> <a href="#">Exit Application</a> </div>		

**Annotation:**

- Click on the blue **Save** box at the bottom of the page.

You should see the following message at the top of the page:

The Provider Enrollment details have been saved successfully. Please note your Application Tracking Number ##### for future access to the Enrollment Application.

STEP 12: Skip the **Provider Identifier Numbers Section 3** page.

STEP 13: Go to the **Service Location/Billing Information Section 4** page by either clicking in the **Application Links** section (top left hand column) or the **Continue button** on the bottom of the page. Enter the information as directed below:

Enter physical address.  
Then click on the **Validate Address** button.  
Choose an option and verify.

Click on the **Add Service Location Phone Numbers** to get the drop down box. Enter the information.  
Click on **Save**. If more than one number, repeat steps to add.

Click on **Add service location contact person**. This is the person in your agency you want contacted to answer service questions.  
Add the information and click on **Save**.

The screenshot shows the 'Service Location Information - Section 4' form. It includes fields for Physical Address, Building, Suite #, etc., City, State (dropdown), Zip, and County. A 'Validate Address' button is located below the address fields. To the right, there is a section for 'Add Service Location Phone Numbers' with a dropdown for 'Phone #' and a 'Fax #' field. Below this is the 'Add Location Numbers' section with 'Phone #' and 'Fax #' fields. At the bottom, there is a section for 'Service Location Contact Person(s)' with a table of columns: Last Name, First Name, MI, Phone, Ext., Fax, Cell Phone, Mail, and Position. Below the table is the 'Add Service Location Contact Person(s)' form with fields for Last Name, First Name, MI, Phone, Ext., Fax, Cell Phone, Email, and Position. Arrows from the text boxes point to the 'Validate Address' button, the 'Add Service Location Phone Numbers' dropdown, and the 'Add service location contact person' button.

Gender Served: Always choose **Both**

Age Range Served: Always choose **All**

Add additional languages if your staff fluently speak them

**Service- Section 4**

\*Gender Served:  
☐ Male ☐ Female ☒ Both

\*Age Range Served:  
☒ All  
☐ 0-5 Years ☐ 6-12 Years  
☐ 13-17 Years ☐ 18-21 Years  
☐ 22-59 Years ☐ 60+ Years

\*Languages Supported:  
 Available: Albanian, American Sign Language, Arabic, Bangla  
 Selected: English  
 Other Language:

**Service Area**

\*Please define your service area by Counties served, or by distance from your location.  
☐ Counties Served ☒ Distance From Location

\*Distance From Location: No Limit

? \*Is this location wheelchair accessible?  
☐ Yes ☒ No

? \*Is this location TDD/TTY Equipped?  
☐ Yes ☒ No

? \*Does this location provide after-hours services?  
☐ Yes ☒ No

? \*Are you a pharmacy or do you provide pharmacy services?  
☐ Yes ☒ No

? \*Are you a 340b Provider?  
☐ Yes ☒ No

? \*Do you wish to be excluded from public provider searches?  
☐ Yes ☒ No

Choose **Distance from Location**;  
 In drop down box choose **No Limit**. This does not influence your actual service area – that will be entered later.

Answer **Yes or No** to each of these questions

**Hours Of Operation**

Add Hours of Operation

Day of Week	Open	Close

Save | Reset | Cancel

\*Day of Week:  \*Open:  \*Close:

**Interpretive Services Available**

Add Interpretive Services Available

Interpretive Services Available

Save | Reset | Cancel

\*Interpretive Service Available:

**Special Needs**

☐ Mental Health Disabilities  
☐ Substance Abuse Disabilities  
☐ Development Disabilities  
☐ Behaviorally Disruptive Disabilities  
☐ Other Disabilities

☐ Deaf/Hearing Impaired Disabilities  
☐ HIV/AIDS Disabilities  
☐ Physical Handicapped Disabilities  
☐ Sexually Aggressive Disabilities  
☐ Blind/Visually Impaired Disabilities

Complete these sections if applicable

Skip this section

**Facility**

**Facility Data**

**Facility Type** **Begin Date** **End Date**

**Bed Capacity Data**

**Clinical Laboratory Improvement Amendments (CLIA)**

Skip these sections

Add Facility Data

**Mailing Address**

\*Is this mailing address the same as service location?  
☒ Yes ☐ No

Mailing Location Phone Numbers

Phone Number

Mailing Location Contact Person(s)

Mailing Location Contact Person(s)

Last Name First Name Middle Initial Phone Ext. Fax Email

Electronic Funds Transfer (EFT) Payments

? \*Do you wish to participate in Electronic Funds Transfer Payments?  
☐ Yes ☒ No

Click **Yes** if mailing address is same as service location. Click **No** if different and add address into drop down box. Validate the address.

Enter this information if the service and the mailing address **are not the same**. Enter the contact person for billing questions.

Add Mailing Location Numbers

Add Mailing Location Contact Person

Check **No**.  
 This information will be entered by HCBS Medical Services staff from the enrollment forms currently on file.



**Billing Address**

Note: The billing address is equivalent to your Pay To address where your checks will be mailed.

\*Is this billing address the same as the service location?  
☐ Yes ☐ No

Enter this information if the service and billing address are not the same. This is the person we will contact if there are questions about your billing.

Billing Location Phone Numbers

Phone Number^v

Add Billing Location Phone Numbers

Billing Location Contact Person(s)

Add Billing Location Contact Person

Last Name^v	First Name^v	Middle Initial^v	Phone Number^v	Extension^v	Fax^v	Position^v	Email^v

**Remittance Advice**

\*Requested Delivery Media for Remittance Advices(RAs)

☐ Electronic (835) ☐ Web Portal Inbox ☒ Paper

Note: The provider can only choose one RA option. Your paper RA will be sent to the billing address listed.

Choose one

Choose these options

**Other Details**

Print Suspense  
Do Not Print Suspended Claims v

RA Sort Ind  
Member's Name v

Bulletin Media  
Paper v

Continue>> Reset Save Exit Application

Click on the blue **Save** button at the bottom of the page.

You should see the following message at the top of the page:

The Provider Enrollment details have been saved successfully. Please note your Application Tracking Number ##### for future access to the Enrollment Application.

STEP 14: Skip the **Group Affiliation – Section 5** page by clicking **continue** or using the application links in the left hand column.

STEP 15: Go to the **Electronic Transaction Submission** page by clicking **continue** or using the application links in the left hand column.

**Electronic Transaction Submission- Section 6**

Providers, who choose to submit claims electronically, must be aware that payment of claims will be from federal and state funds and that any falsification or concealment of material fact may be prosecuted under Federal and State laws. Further, providers must understand and agree to do the following:

- Safeguard against abuse in the use of electronic claims submission.
- Correctly enter the claims data, monitor the data, and certify that the data entered is correct.
- Assure that the transmission of claims data is restricted to authorized personnel to prevent erroneous payments which might result from carelessness or fraud.
- Have on file the applicable documentation to substantiate any claims submitted.
- Allow the agency or any of its designees and representatives to review and copy all records, including source documents and data related to information entered through electronic claims submission.
- Abide by all Federal and State statutes, rules, regulations, and manuals governing North Dakota programs.
- Sign and adhere to all conditions of the Provider Agreement and be officially enrolled in the program to participate in electronic claims submission.

**Indicate which of the following will be used to submit transactions electronically:**

☒ North Dakota MMIS Web Portal

☐ Vendor Software

☐ Billing Agent/Clearinghouse

**Click on North Dakota MMIS Web Portal**

**Continue>>   Reset   Save   Exit Application**

Click **Save** at the bottom of the page.

You should see the following message at the top of the page:

The Provider Enrollment details have been saved successfully. Please note your Application Tracking Number ##### for future access to the Enrollment Application.

STEP 16: Click the **Continue** button or use the Application Links on the left hand side of the page to go to Ownership – Section 7 page.

Ownership- Section 7

? \*1. How many owners of this applicant have a 5% or more ownership interest in the group?  
0

Add Ownership

**Ownership**

Name	Doing Business As (DBA) Name	Effective Date of Ownership	Current ND Provider #
Please enter ownership information for each owner included in the number above			

? \*2. Are any of the persons with an ownership or controlling interest in the provider's company related to one another as spouse, parent, child, sibling or household member?  
☐ Yes ☐ No

? \*3. What is the total number of managing/directing employees for the group?  
Please enter employee information for each employee included in the number entered.  
0

Add Employee

**Employee**

Last Name	First Name	MI	Title	Date of Birth
? *5. Do any of the members of your immediate family (spouse, parent, child, sibling or household member) have ownership of 5% or greater in a subcontractor to your business or practice? (A subcontractor is an individual, agency, or organization to which an applicant/provider has contracted responsibilities of providing medical care to its patients.) <input type="radio"/> Yes <input checked="" type="radio"/> No				

Continue>> Reset Save Exit Application

See the Help section in the left hand column. Answer the questions. Use your current SFN 1168 to find the information.

Please note that the SFN 1168 Ownership & Controlling Interest form on file with Medical Services will be used as the official record as this ownership section does not contain all current CMS requirements.

Click on the blue **Save** button at the bottom of the page.

You should see the following message at the top of the page:

The Provider Enrollment details have been saved successfully. Please note your Application Tracking Number ##### for future access to the Enrollment Application.

Click **Continue**.

STEP 17: Skip the **Authorized Representatives** page.

STEP 18: Continue to the **Exclusion/Sanctions – Section 7** page, Answer all questions.

**Exclusion / Sanction- Section 7**

**\*1.** Are any of the named owners related to owners of the subcontractor as spouse, parent, child, sibling or household member?

☐ Yes ☐ No

**\*2.** Is the group chain affiliated?

☐ Yes ☐ No

**\*3.** Is the group operated by a management company or leased in whole or part by another organization?

☐ Yes ☐ No

**\*4.** Are there any individuals or organizations having a direct or indirect ownership or controlling interest of 5% or more in the group that have been convicted of a criminal offense related to involvement of such individuals, or organization in any of the programs established by Medicare, Medicaid, and State Health Insurance Programs?

☐ Yes ☐ No

**\*5.** Are there any directors, officers, agents, or managing employees of the group that have ever been convicted of a criminal offense related to their involvement in such programs established by Medicare, Medicaid, and State Health Insurance Program?

☐ Yes ☐ No

**\*6.** Has any family or household member or any person who has ownership or controlling interest in the group, ever been convicted, assessed, or excluded from State or Federal programs due to fraud, obstruction of an investigation or a controlled substance violation?

☐ Yes ☐ No

**\*7.** Does the applicant under any name or business identity, have any outstanding overpayments with any state or federal program?

☐ Yes ☐ No

**\*8.** Has the applicant ever been convicted of a felony under Federal or State Law?

☐ Yes ☐ No

If you have ever had any of the following adverse legal actions imposed or are pending by any federal or state agency or program, check the appropriate box and indicate the date when the adverse legal action was imposed.

**Important:** Attach copy of adverse legal action notification(s).

**\*9.** Administrative Sanction(s)?

☐ Yes ☐ No

**\*10.** Professional Board Disciplinary Action(s)?

☐ Yes ☐ No

**\*11.** Program Exclusions?

☐ Yes ☐ No

**\*12.** Suspension of Payments?

☐ Yes ☐ No

**\*13.** Civil Monetary Penalty(s)?

☐ Yes ☐ No

**\*14.** Assessment(s)?

☐ Yes ☐ No

? \*15. Program Debarment(s)?  
☐ Yes ☐ No

? \*16. Criminal Fine(s)?  
☐ Yes ☐ No

? \*17. Restitution Order(s)?  
☐ Yes ☐ No

? \*18. Pending Civil Judgment(s)?  
☐ Yes ☐ No

? \*19. Pending Criminal Judgment(s)?  
☐ Yes ☐ No

? \*20. Judgment(s) Pending under the False Claims Act?  
☐ Yes ☐ No

Continue>> Reset Save Exit Application

Click on the blue **Save** button at the bottom of the page.

You should see the following message at the top of the page:

The Provider Enrollment details have been saved successfully. Please note your Application Tracking Number ##### for future access to the Enrollment Application.

Click **Continue**.

STEP 19: This will take you to the **Agency Qualified Service Provider** page.

**Agency Qualified Service Provider**

County(s) where service will be provided Available

001-Adams  
002-Barnes  
003-Benson  
004-Billings

Selected

004-Burleigh

Enter the counties in which your agency currently provides QSP services using the over arrow

**Agency Qualified Service Provider Global Endorsements**

QSP Global Endorsements Available

Catheter  
Cognitive/Supervision  
Exercise  
Hoyer Lift/Mechanized Bath Chair

Selected

QSP Global Endorsements Sought Available

Catheter  
Cognitive/Supervision  
Exercise  
Hoyer Lift/Mechanized Bath Chair

Selected

Skip this side

Enter the global endorsements for which you are currently enrolled by highlighting and using the over arrow. Refer to your most recent enrollment letter if unsure of your current global endorsements.

Each of the statements below must be initialed with the initials of the person authorized to sign the application.

**Qualified Service Provider Questionnaire**

☐ The Agency will notify the clients case manager or the County Social Service Office when any of the following occur.  
1. Client is not home at the time scheduled for service;  
2. Observed change in client's physical, cognitive, emotional, and/or environmental condition;  
3. Change in the amount or type of service that may be needed by the client;  
4. Possible abuse or exploitation of client;  
5. Other circumstances as agreed upon with case manager for specific client(s)

☐ The Agency will adhere to applicable federal and state laws.

☐ The Agency will provide care at a level acceptable to the client and the Department of Human Services.

☐ The Agency cannot be compensated for services provided to a client by the direct care person who is the spouse, parent, child (client) under 18 years of age, or has been ordered by the court to provide such care.

☐ The Agency will retain records for a period of 42 months from the close of Federal fiscal year (October 1 September 30) in which the services are delivered and will provide records to the Department of Human Services (Department) upon request.

☐ The Agency will not assign employees to provide services to public pay clients if the employee has been convicted of a felony or misdemeanor offense that has direct bearing to the ability to provide care and be in compliance with ND Administrative Code 75-03-23-97.

☐ The Agency will assure that all employees providing non-medical transportation services meet all the non-medical transportation standards listed in the In-Home Services Qualified Service Provider Handbook.

☐ The Agency will not assign an employee to deliver the service until it is documented and on file that he/she meets all the required standards, printed in the Qualified Service Provider handbook, including any endorsements that may be required for the service.

☐ The Agency will not assign an employee to provide services in an Adult Family Foster Care Home until a background check has been completed by the Department.

☐ The Department can request a refund or process adjustments to take back payment made to a provider if the provider does not provide the requested records or keep appropriate records.

☐ The Agency will assure an infectious/contagious self declaration form is on file and update every two years for staff who provide services to public pay clients.

☐ Agency staff will review the Home Fire Safety Fact Sheet enclosed in the application packet.

**Non-Medical Provider (meals, lodging, transportation)**

List your Medicaid eligible recipients.  
You must list at least one recipient to enroll as a provider.

Add Medicaid Eligible Recipients

Medicaid ID	Last Name	First Name	MI

All Transportation Providers: You are required to submit with your application a copy of your current valid driver's license and proof of insurance.

Continue>> Save Reset Exit Application

Skip this section

Click on the blue **Save** button at the bottom of the page.

You should see the following message at the top of the page:

The Provider Enrollment details have been saved successfully. Please note your Application Tracking Number ##### for future access to the Enrollment Application.

STEP 20: Click on **Continue** to go to **Submit Application** page – Read the **Provider Agreement**.

The screenshot shows a web browser window titled "Provider Enrollment - Submit Application Step 1". On the left is a sidebar with "Application Links" including "Application Tracking Number - 130840", "Instructions", and various status indicators for "Identifying Information", "Licensure / Certification", "Provider Identifier Numbers", "Service Location / Billing Information", "Group Affiliation", "Electronic Transaction Submission", "Ownership", "Authorized Reps", "Exclusions / Sanctions", and "Qualified Service Providers". The "Submit Application" link is highlighted. The main content area has a "Provider Agreement" section with a list of agreements to read. Below this is a "Register for Web Access" section with a "Yes" radio button selected. The form includes fields for "Organization Name" (with Prefix, Last Name, First Name, MI, and Suffix sub-fields), "Organization Description", "User ID", "Phone #", "Ext", and "Email Address". At the bottom is a "Validate Application" section with a "Save" button and a "Validate Application" button. Annotations with arrows point to the "Yes" radio button, the "Organization Name" field, the "Organization Description" field, the "User ID" field, and the "Validate Application" button.

Leave the default of Yes

Enter Agency Legal Name

Organization Description – enter QSP

User ID: Use first initial of first name and last name of the person who will do the billing. Click **Save** – if not accepted choose one of the suggestions listed in red. Click **Save** again. **Write down the User ID along with the Application Tracking Number.**

Click on **Validate Application**

User ID: \_\_\_\_\_

STEP 21: Follow the directions below:

Provider Enrollment - Submit Application Step 2 Print | Help

\* Required Field

**Application Links**

- Application Tracking Number - 130840
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location / Billing Information
- Group Affiliation
- Electronic Transaction Submission
- Ownership
- Authorized Reps
- Exclusions / Sanctions
- Qualified Service Providers
- Submit Application**

**Add Another Service Location**

If you render services at any locations other than the service address entered, click the 'Add Another Service Location' button to enter an additional location and the location-specific information. You may use this button to enter all locations where you render services.

**Edit Service Location**

If after validation you need to edit information related to your additional locations, click the 'Edit Service Location' button to see all locations entered, and select the location you want to edit.

**Edit Application**

If you need to edit your application click the 'Edit Application' button to make the necessary changes.

**Electronic Signature**

☐ \*I have read and agree to all terms and conditions stated in the Provider Agreement.

☐ \*I have read and agree to all terms and conditions stated in the PCCM Agreement.

☐ \*I have read and agree to all terms and conditions stated in the Trading Partner Agreement.

**Requested Claim Submission Effective Date**

Requested Claim Submission Effective Date

**Submit Confirmation**

When you finish making changes and/or adding service locations, please submit the application. Click the 'Confirm Submit' button below to submit your web-based application to Provider Enrollment. A confirmation message screen will be displayed on the next page. After submitting, you can no longer make any changes to your application.

If you have any questions, please contact Provider Enrollment at (800) 755-2604.

Skip this →

Click only "I have read and agree to all terms and conditions stated in the Provider Agreement." This is the SFN 615 Medicaid Program Provider Agreement that is on file with your enrollment forms.

Click on the blue **Save** button at the bottom of the page.

You should see the following message at the top of the page:

The Provider Enrollment details have been saved successfully. Please note your Application Tracking Number ##### for future access to the Enrollment Application.

Then click on **Confirm Submit**.



STEP 22: You will be taken to the screen below:

Provider Enrollment - Submit Complete Print | Help

\* Required Field

Thank you for submitting your application on-line. You should receive email confirmation soon. Click PRINT APPLICATION button to print a completed copy of your application for your records. This copy is for your records only and not to be sent into DHS. Once you have printed all the above, click EXIT APPLICATION button to exit the application form and return to the Medicaid Provider Enrollment home page.

**Application Tracking Number**

**Application Tracking Number :130840**

Your Application Tracking Number is: 130840 Please record your Application Tracking Number. Use this number when inquiring about your application status.

**NOTE:** Providers should also write this Application Tracking Number on all documents that are mailed to the Medicaid Program.

**Print and Review**

The Print Application button may be used to print a copy of the application. This copy is for your records only and should not be sent to DHS. The application will remain available to you on the portal for 30 days after submittal.

Additional documents may be required to be sent in as attachments to your application depending on your provider type. Print the Document Requirements Checklist to identify the supplemental information by provider type that is needed to finalize your application. Mail all additional enrollment documentation to:

**Note:** Include the application tracking number indicated above on all documents that are mailed to DHS in reference to your application.

**North Dakota Department of Human Services**  
**Provider Enrollment**  
600 E Boulevard Avenue Dept 325  
Bismarck ND 58505-0250

**Print Required Documents**

1. [Document Requirements Checklist](#)

Once the required document has been printed, click the Exit Application button to return to the ND Provider Enrollment Homepage

Print Application Exit Application

If you have any questions, please call DHS at (800) 755-2604.

The Documents Requirements Checklist does not apply.

**You should not send any additional documentation.** Remember we have your current written QSP Agency enrollment forms and documents on file.

Print the application for your file. Make sure you have written down the Application Tracking Number for future reference.

Click on **Exit Application**.

- Remember - your agency must be entered into the North Dakota MMIS Web Portal **no later than June 1, 2014** for your claims/payments to pay when the new billing system starts.
- Medical Services will send you a written notice that the application has been approved. That will be the verification that you are enrolled into the new MMIS system.